ForwardHealth
Wisconsin serving you

Update
July 2008

No. 2008-114

Affected Programs: BadgerCare Plus, Medicaid
To: Nursing Homes, Occupational Therapists, Physical Therapists, Rehabilitation Agencies, Speech and Hearing Clinics, Speech-Language Pathologists, Therapy Groups, HMOs and Other Managed Care Programs

Changes to Prior Authorization for Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services

This *ForwardHealth Update* introduces important changes to prior authorization (PA) for physical therapy, occupational therapy, and speech and language pathology services, effective October 2008, with the implementation of the ForwardHealth interChange system. These changes include the following:

- Establishing deadlines for providers to respond to returned PA requests and PA amendment requests.
- Revising all PA forms. The following PA forms will be available to download and print from the Web at *dhs.wisconsin.gov/ForwardHealth/*:
  - ✓ Prior Authorization Request Form (PA/RF), F-11018 (10/08).
  - ✓ Prior Authorization Amendment Request, F-11042 (10/08).
  - ✓ Prior Authorization/Therapy Attachment (PA/TA), F-11008 (10/08).
  - ✓ Prior Authorization/Spell of Illness Attachment (PA/SOIA), F-11039 (10/08).
  - ✓ Prior Authorization/Birth to 3 Therapy Attachment (PA/B3), F-11011 (10/08).

Providers may also order copies from Provider Services.

The changes were made to do the following:

- Provide efficiencies for both providers and ForwardHealth.
- Accommodate changes required for full National Provider Identifier implementation.
- Align with Health Insurance Portability and Accountability Act of 1996 (HIPAA) terminology.

A separate *Update* will give providers a calendar of additional important dates related to implementation including when to begin submitting the revised PA forms.

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Information in this *Update* applies to providers who provide services for BadgerCare Plus Stanard Plan and Wisconsin Medicaid members..

Changes to Prior Authorization with the Implementation of ForwardHealth interChange

In October 2008, the Department of Health and Services (DHS) will implement ForwardHealth interChange, which replaces Wisconsin's existing Medicaid Management Information System (MMIS). ForwardHealth interChange will be supported as part of the State's new fiscal agent contract with EDS. With ForwardHealth interChange, providers and trading partners will have more ways to verify member enrollment, and submit electronic claims, adjustments,

and prior authorization requests through the secure ForwardHealth Portal. Refer to the March 2008 ForwardHealth Update (2008-24), titled "Introducing ForwardHealth interChange, a New Web-Based Information System for State Health Care Programs," for an overview of the implementation and a more detailed outline of the many business process enhancements and added benefits the new system and fiscal agent contract will provide.

With the implementation of the ForwardHealth interChange system, important changes will be made to PA forms and procedures that are detailed in this *Update*. These changes are not policy or coverage related (e.g., PA requirements, documentation requirements). The changes were made to:

- Provide efficiencies for both providers and ForwardHealth. Providers will be able to submit PA requests and receive decisions and requests for additional information via the ForwardHealth Portal.
- Accommodate changes required for full National Provider Identifier (NPI) implementation. Prior authorization forms were revised to include elements for providers to indicate NPI and taxonomy information.
- Align with Health Insurance Portability and Accountability Act of 1996 (HIPAA) terminology.

Note: Specific implementation dates will be published in a separate *Update*. Use of information presented in this *Update* prior to implementation may result in returned PA requests.

Information in this *Update* applies to providers who provide services for BadgerCare Plus Standard Plan and Wisconsin Medicaid members.

Submitting Prior Authorization Requests

Using the ForwardHealth Portal, providers will be able to submit PA requests for *all* services requiring PA. In addition to the Portal, providers may submit PA requests via any of the following:

- Fax at (608) 221-8616.
- Mail to the following address:

  ForwardHealth
  Prior Authorization
  Ste 88
  6406 Bridge Rd
  Madison WI 53784-0088

Watch for future publications for information on submitting PA requests via the Portal.

Prior Authorization Numbers

The PA number will no longer be pre-printed on the Prior Authorization Request Form (PA/RF), F-11018 (10/08). As a result, providers will be able to download and print the form from the Portal and no longer have to order pre-printed forms from ForwardHealth. Upon receipt of the form, ForwardHealth will assign a PA number to each PA request.

The PA number will consist of 10 digits, containing valuable information about the PA (e.g., the date the PA request was received by ForwardHealth, the medium used to submit the PA request). Refer to Attachment 1 of this *Update* for information about interpreting PA numbers.

Changes to Prior Authorization Forms

With the implementation of ForwardHealth interChange, physical therapy (PT), occupational therapy (OT), and speech and language pathology (SLP) services providers submitting a paper PA request will be required to use the revised PA/RF. Refer to Attachments 2 and 3 for completion instructions and a copy of the PA/RF for providers to photocopy. Attachment 4, 5, and 6 are sample PA/RFs for PT, OT, and SLP services.

Note: If ForwardHealth receives a PA request on a previous version of the PA/RF, a letter will be sent to the provider stating that the provider is required to submit a new PA request using the proper forms. This may result in a later grant date if the PA request is approved.

Revisions to the Prior Authorization Request Form and Instructions

The following revisions have been made to the PA/RF:

- The PA number is eliminated from the form.
- The paper PA/RF is a one-part form (no longer a two-part, carbonless form) that can be downloaded and printed. The PA/RF is available in two formats on the Portal — Microsoft® Word and Portable Document Format (PDF).
- Checkboxes are added for HealthCheck "Other Services" and Wisconsin Chronic Disease Program (WCDP) (Element 1) to create efficiencies for providers who render services to members in Wisconsin Medicaid, BadgerCare Plus, and WCDP.
- The term "rendering provider" replaces "performing provider" to align with HIPAA terminology.
- Billing and rendering provider taxonomy code fields are added (Elements 5b and 17) to accommodate NPI implementation.
- In the billing provider's name and address fields, providers are now required to include the ZIP+4 code (Element 4) to accommodate NPI implementation.

Prior Authorization Attachments

With the implementation of ForwardHealth interChange, PT, OT, and SLP services providers submitting a paper PA request will be required to use the revised Prior Authorization/Therapy Attachment (PA/TA), F-11008; Prior Authorization/Spell of Illness Attachment (PA/SOIA), F-11039; and Prior Authorization/Birth to 3 Therapy Attachment (PA/B3), F-11011. While the basic information requested on the form has not changed, the format of the form has changed to accommodate NPI information and to add a barcode. ForwardHealth will scan each form with a barcode as it is received, which will allow greater efficiencies for processing PA requests.

Refer to Attachments 7 and 9 for copies of the completion instructions for the PA/TA and PA/SOIA. Attachments 8, 10, and 11 are copies of the PA/TA, PA/SOIA, or PA/B3 for providers to photocopy.

Obtaining Prior Authorization Request Forms and Attachments

The PA/RF and the PA/TA, PA/SOIA, and PA/B3 are available in fillable PDF or fillable Microsoft® Word from the Forms page at *dhs.wisconsin.gov/ForwardHealth/* prior to implementation and will be available from the Portal after implementation.

The fillable PDF is accessible using Adobe Reader® and may be completed electronically.

To request a paper copy of the PA/RF or the PA/TA, PA/SOIA, or PA/B3 for photocopying, call Provider Services at (800) 947-9627. Questions about the forms may also be directed to Provider Services.

In addition, a copy of any PA form and/or attachment is available by writing to ForwardHealth. Include a return address, the name of the form, and the number of the form (if applicable) and mail the request to the following address:

ForwardHealth
Form Reorder
6406 Bridge Rd
Madison WI 53784-0003

Prior Authorization Decisions

The PA review process continues to include both a clerical review and a clinical review. The PA request will have one of the statuses detailed in the following table.

Prior Authorization Status	Description
Approved	The PA request was approved as requested.
Approved with Modifications	The PA request was approved with modifications to what was requested.
Denied	The PA request was denied.
Returned — Provider Review	The PA request was returned to the provider for correction or for additional information.
Pending — Fiscal Agent Review	The PA request is being reviewed by the Fiscal Agent.
Pending — Dental Follow-up	The PA request is being reviewed by a Fiscal Agent dental specialist.
Pending — State Review	The PA request is being reviewed by the State.
Suspend — Provider Sending Information	The PA request was submitted via the ForwardHealth Portal and the provider indicated they will be sending additional supporting information on paper.
Inactive	The PA request is inactive due to no response within 30 days to the returned provider review letter and cannot be used for PA or claims processing.

Communicating Prior Authorization Decisions

ForwardHealth will make a decision regarding a provider's PA request within 20 working days from the receipt of all the necessary information. After processing the PA request, ForwardHealth will send the provider either a decision notice letter or a returned provider review letter. Providers will receive a decision notice letter for PA requests that were approved, approved with modifications, or denied. Providers will receive a returned provider review letter for PA requests that require corrections or additional information. The new decision notice letter or returned provider review letter implemented with ForwardHealth interChange will clearly indicate what is approved or what correction or additional information ForwardHealth needs to continue adjudicating the PA request.

Providers submitting PA requests via the Portal will receive a decision notice letter or returned provider review letter via the Portal.

If the provider submitted a PA request via mail or fax and the provider has a Portal account, the decision notice letter or returned provider review letter will be sent to the provider via the Portal as well as by mail.

If the provider submitted a paper PA request via mail or fax and does not have a Portal account, the decision notice letter or returned provider review letter will be sent to the address indicated in the provider's file as his or her PA address (or to the physical address if there is no PA address on file), *not* to the address the provider wrote on the PA request.

The decision notice letter or returned provider review letter will not be faxed back to providers who submitted their paper PA request via fax. Providers who submitted their paper PA request via fax will receive the decision notice letter or returned provider letter via mail.

Returned Provider Review Letter

The returned provider review letter will indicate the PA number assigned to the request and will specify corrections or additional information needed on the PA request. Providers are required to make the corrections or supply the requested information in the space provided on the letter or attach additional information

to the letter before mailing the letter to ForwardHealth. Providers can also correct PAs that have been placed in returned provider review status in the Portal.

The provider's paper documents submitted with the PA request will no longer be returned to the provider when corrections or additional information are needed. Therefore, providers are required to make a copy of their PA requests (including attachments and any supplemental information) before mailing the requests to ForwardHealth. The provider is required to have a copy on file for reference purposes if ForwardHealth requires more information about the PA request.

Note: When changing or correcting the PA request, providers are reminded to revise or update the documentation retained in their records.

Thirty Days to Respond to the Returned Provider Review Letter

ForwardHealth must receive the provider's response within 30 calendar days of the date on the returned provider review letter, whether the letter was sent to the provider by mail or through the Portal. If the provider's response is received within 30 calendar days, ForwardHealth will still consider the original receipt date on the PA request when authorizing a grant date for the PA.

If ForwardHealth does not receive the provider's response within 30 calendar days of the date the returned provider review letter was sent, the PA status becomes inactive and the provider is required to submit a new PA request. This will result in a later grant date if the PA request is approved. Providers will not be notified when their PA request status changes to inactive, but this information will be available on the Portal and through the WiCall Automated Voice Response system. Watch for future publications for more information regarding checking PA status via WiCall.

If ForwardHealth receives additional information from the provider after the 30-day deadline has passed, a letter will be sent to the provider stating that the PA request is inactive and the provider is required to submit a new PA request.

Listing Procedure Codes Approved as a Group on the Decision Notice Letter

In certain circumstances, ForwardHealth will approve a PA request for a group of procedure codes with a total quantity approved for the entire group. When this occurs, the quantity approved for the entire group of codes will be indicated with the first procedure code. All of the other approved procedure codes within the group will indicate a quantity of zero.

Providers may submit claims for any combination of the procedure codes in the group up to the approved quantity.

New Amendment Process

Providers are required to use the Prior Authorization Amendment Request, F-11042 (10/08), to amend an approved or modified PA request. The Prior Authorization Amendment Request was revised to accommodate NPI information.

Instructions for completion of the Prior Authorization Amendment Request are located in Attachment 12. Attachment 13 is a copy of the revised Prior Authorization Amendment Request for providers to photocopy.

ForwardHealth does not accept a paper amendment request submitted on anything other than the Prior Authorization Amendment Request. The Prior Authorization Amendment Request may be submitted through the Portal as well as by mail or fax. If ForwardHealth receives a PA amendment on a previous version of the Prior Authorization Amendment Request form, a letter will be sent to the provider stating that the

provider is required to submit a new PA amendment request using the proper forms.

ForwardHealth will make a decision regarding a provider's amendment request within 20 working days from the receipt of all the information necessary. If the provider submitted the amendment request via the Portal, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal.

If the provider submitted an amendment request via mail or fax and the provider has a Portal account, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal as well as by mail.

If the provider submitted a paper amendment request via mail or fax and does not have a Portal account, the decision notice letter or returned amendment provider review letter will be sent to the address indicated in the provider's file as his or her PA address (or to the physical address if there is no PA address on file), *not* to the address the provider wrote on the amendment request.

Neither the decision notice letter nor the returned amendment provider review letter will be faxed back to providers who submitted their paper amendment request via fax. Providers who submitted their paper amendment request via fax will receive the decision notice letter or returned amendment provider review letter via mail.

Returned Amendment Provider Review Letter

If the amendment request needs correction or additional information, a returned amendment provider review letter will be sent. The letter will show how the PA appears currently in the system and providers are required to respond by correcting errors identified on the letter. Providers are required to make the corrections or supply the requested information in the space provided on the letter or attach additional information to the letter before mailing the letter to ForwardHealth. Providers can also correct an amendment request that has been placed in returned provider review status in the Portal.

ForwardHealth must receive the provider's response within 30 calendar days of the date the returned amendment provider review letter was sent. After 30 days the amendment request status becomes inactive and the provider is required to submit a new amendment request. The ForwardHealth interChange system will continue to use the original approved PA request for processing claims.

The provider's paper documents submitted with the amendment request will no longer be returned to the provider when corrections or additional information are needed. Therefore, providers are required to make a copy of their amendment requests (including attachments and any supplemental information) before mailing the requests to ForwardHealth. The provider is required to have a copy on file for reference purposes if ForwardHealth requires more information about the amendment request.

Note: When changing or correcting the amendment request, providers are reminded to revise or update the documentation retained in their records.

Valid Diagnosis Codes Required

Effective with implementation, the PA/RF will be monitored for the most specific *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis codes for all diagnoses. The required use of valid diagnosis codes includes the use of the most specific diagnosis codes. Valid, most specific, diagnosis codes may have up to five digits.

Prior authorization requests sent by mail or fax with an invalid diagnosis code will be returned to the provider. Providers using the Portal will receive a message that the

diagnosis code is invalid and will be allowed to correct the code and submit the PA request.

Information Regarding Managed Care

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis. For managed care policy, contact the appropriate managed care organization. HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *dhs.wisconsin.gov/forwardhealth/*.

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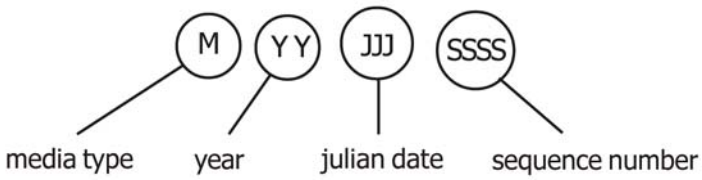
ATTACHMENT 1
Interpreting Prior Authorization Numbers

Each prior authorization (PA) request is assigned a unique PA number. This number identifies valuable information about the PA. The following diagram and table provide detailed information about interpreting the PA number.



Type of Number and Description	Applicable Numbers and Description
Media — One digit indicates media type.	Digits are identified as follows: 1= paper; 2 = fax; 3 = Specialized Transmission Approval Technology-Prior Authorization (STAT-PA); 4 = STAT-PA; 5 = Portal; 6 = Portal; 7 = National Council for Prescription Drug Programs (NCPDP) transaction
Year — Two digits indicate the year ForwardHealth received the PA request.	For example, the year 2008 would appear as 08.
Julian date — Three digits indicate the day of the year, by Julian date, that ForwardHealth received the PA request.	For example, February 3 would appear as 034.
Sequence number — Four digits indicate the sequence number.	The sequence number is used internally by ForwardHealth.

ATTACHMENT 2
Prior Authorization Request Form (PA/RF) Completion Instructions for Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. The use of this form is mandatory to receive PA of certain procedures/services/items. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests, along with the Prior Authorization/Therapy Attachment (PA/TA), F-11008; Prior Authorization/Spell of Illness Attachment (PA/SOIA), F-11039; and the Prior Authorization/Birth to 3 Therapy Attachment (PA/B3), F-11011, by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — PROVIDER INFORMATION

Element 1 — HealthCheck "Other Services" and Wisconsin Chronic Disease Program (WCDP)
Enter an "X" in the box next to HealthCheck "Other Services" if the services requested on the Prior Authorization Request Form (PA/RF), F-11018, are for HealthCheck "Other Services." Enter an "X" in the box next to Wisconsin Chronic Disease Program (WCDP) if the services requested on the PA/RF are for a WCDP member.

Element 2 — Process Type
Enter the appropriate three-digit process type from the list below. The process type is a three-digit code used to identify a category of service requested. Use process type 999 (Other) only if the requested category of service is not found in the list. Prior authorization and SOI requests will be returned without adjudication if no process type is indicated.

* 111 — Physical Therapy (PT)
* 112 — Occupational Therapy (OT)
* 113 — Speech and Language Pathology (SLP)
* 114 — SOI for PT
* 115 — SOI for OT
* 116 — SOI for SLP

160 — Birth to 3 (B-3) for PT
161 — B-3 for OT
162 — B-3 for SLP
999 — Other (use only if the requested category or service is not listed above)

*Includes rehabilitation agencies.

Element 3 — Telephone Number — Billing Provider
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

Element 4 — Name and Address — Billing Provider
Enter the name and complete address (street, city, state, and ZIP+4 code) of the billing provider. Providers are required to include both the ZIP code and four-digit extension for timely and accurate billing. The name listed in this element must correspond with the billing provider number listed in Element 5a.

Element 5a — Billing Provider Number
Enter the National Provider Identifier (NPI) of the billing provider. The NPI in this element must correspond with the provider name listed in Element 4.

Element 5b — Billing Provider Taxonomy Code
Enter the national 10-digit alphanumeric taxonomy code that corresponds to the NPI of billing provider number in Element 5a.

SECTION II — MEMBER INFORMATION

Element 6 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth identification card or Wisconsin's Enrollment Verification System (EVS) to obtain the correct number.

Element 7 — Date of Birth — Member
Enter the member's date of birth in MM/DD/CCYY format.

Element 8 — Address — Member
Enter the complete address of the member's place of residence, including the street, city, state, and ZIP code. If the member is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 9 — Name — Member
Enter the member's last name, followed by his or her first name and middle initial. Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

Element 10 — Gender — Member
Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 11 — Diagnosis — Primary Code and Description
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested.

Element 12 — Start Date — SOI
Complete this element only when requesting an SOI. Enter the date of onset for the SOI in MM/DD/CCYY format.

Element 13 — First Date of Treatment — SOI
Complete this element only when requesting an SOI. Enter the date of the first treatment for the SOI in MM/DD/CCYY format.

Element 14 — Diagnosis — Secondary Code and Description
Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service/procedure requested, if applicable. If requesting an SOI, leave this element blank.

Element 15 — Requested PA Start Date
Enter the requested start date for service(s) in MM/DD/CCYY format, if a specific start date is requested. If requesting an SOI, leave this element blank.

Element 16 — Rendering Provider Number
Enter the NPI of the provider who will be performing the service, *only* if the NPI is different from the NPI of the billing provider listed in Element 5a. If the treating therapist is the therapy assistant, enter the provider number of the supervising therapist. Rehabilitation agencies and outpatient hospital PT, OT, and SLP providers do not indicate a rendering provider number.

Element 17 — Rendering Provider Taxonomy Code
Enter the national 10-digit alphanumeric taxonomy code that corresponds to the provider who will be performing the service, *only* if this code is different from the taxonomy code listed for the billing provider in Element 5b. If the treating therapist is a therapy

assistant, enter the provider number of the supervising therapist. Rehabilitation agencies and outpatient hospital PT, OT, and SLP providers do not indicate a rendering provider number.

Element 18 — Procedure Code
Enter the appropriate *Current Procedural Terminology* (CPT) code; National Uniform Billing Committee (NUBC) code, Healthcare Common Procedure Coding System (HCPCS) code, National Drug Code (NDC), or ICD-9-CM surgical code for each service/procedure/item requested. Do not complete this element if requesting a B-3 program service.

Element 19 — Modifiers
Enter the modifier(s) corresponding to the procedure code listed if a modifier is required. Enter the "GP" modifier for PT services and the "GO" modifier for OT services. No modifier is needed for SLP services. Do not enter modifiers "TF" or "TL."

Element 20 — POS
Enter the appropriate place of service (POS) code designating where the requested service/procedure/item would be provided/performed/dispensed.

Element 21 — Description of Service
Enter a written description corresponding to the appropriate CPT code, NUBC code, HCPCS code, NDC, or ICD-9-CM surgical code for each service/procedure/item requested. If requesting a B-3 service, enter "Birth to 3" and the therapy discipline as the description (e.g., "Birth to 3 occupational therapy services" for OT services).

Element 22 — QR
Enter the appropriate quantity (e.g., number of services, days' supply) requested for the procedure code listed. If requesting a therapy SOI, enter "35" in this element.

Element 23 — Charge
Enter the provider's usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1.0," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element. Do not complete this element if requesting a therapy SOI.

Note: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to provider *Terms of Reimbursement* issued by the Department of Health Services.

Element 24 — Total Charges
Enter the anticipated total charges for this request. Do not complete this element if requesting a therapy SOI.

Element 25 — Signature — Requesting Provider
The original signature of the provider requesting/performing/dispensing this service/procedure/item must appear in this element.

Element 26 — Date Signed

Enter the month, day, and year the PA/RF was signed (in MM/DD/CCYY format).

ATTACHMENT 3
Prior Authorization Request Form (PA/RF)
(for photocopying)

(A copy of the "Prior Authorization Request Form [PA/RF]" is located on the following page.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11018 (10/08)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code
HFS 152.06(3)(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

SECTION I — PROVIDER INFORMATION

1. Check only if applicable ❑ HealthCheck "Other Services" ❑ Wisconsin Chronic Disease Program (WCDP)	2. Process Type	3. Telephone Number — Billing Provider
4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code)		5a. Billing Provider Number 5b. Billing Provider Taxonomy Code

SECTION II — MEMBER INFORMATION

6. Member Identification Number	7. Date of Birth — Member	8. Address — Member (Street, City, State, ZIP Code)
9. Name — Member (Last, First, Middle Initial)	10. Gender — Member ❑ Male ❑ Female	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

11. Diagnosis — Primary Code and Description	12. Start Date — SOI	13. First Date of Treatment — SOI
14. Diagnosis — Secondary Code and Description	15. Requested PA Start Date	

16. Rendering Provider Number	17. Rendering Provider Taxonomy Code	18. Service Code	19. Modifiers 1	2	3	4	20. POS	21. Description of Service	22. QR	23. Charge

An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.

24. Total Charges	

25. **SIGNATURE** — Requesting Provider	26. Date Signed

DT-PA049-001

ATTACHMENT 4
Sample Prior Authorization Request Form for Physical Therapy Services

(A sample copy of the "Prior Authorization Request Form [PA/RF]" for physical therapy services is located on the following page.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11018 (10/08)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code
HFS 152.06(3)(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

SECTION I — PROVIDER INFORMATION

1. Check only if applicable	2. Process Type	3. Telephone Number — Billing Provider
❑ HealthCheck "Other Services" ❑ Wisconsin Chronic Disease Program (WCDP)	**111**	**(XXX) XXX-XXXX**

4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code)	5a. Billing Provider Number	5b. Billing Provider Taxonomy Code
I.M. Billing Provider **609 Willow St** **Anytown WI 55555-1234**	**0222222220**	**123456789X**

SECTION II — MEMBER INFORMATION

6. Member Identification Number	7. Date of Birth — Member	8. Address — Member (Street, City, State, ZIP Code)
1234567890	**MM/DD/CCYY**	**322 Ridge St** **Anytown WI 55555**

9. Name — Member (Last, First, Middle Initial)	10. Gender — Member
Member, Im A.	❑ Male ☒ Female

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

11. Diagnosis — Primary Code and Description	12. Start Date — SOI	13. First Date of Treatment — SOI
434.01		

14. Diagnosis — Secondary Code and Description	15. Requested PA Start Date
437.0 – Cerebral atherosclerosis	

16. Rendering Provider Number	17. Rendering Provider Taxonomy Code	18. Service Code	19. Modifiers 1	2	3	4	20. POS	21. Description of Service	22. QR	23. Charge
0111111110	**123456789X**	**97116**	**GP**				**11**	**Gait training/transferring 15 min x3/wk x 11 wk**	**33**	**XXX.XX**
0111111110	**1234567890**	**97110**	**GP**				**11**	**Strengthening exercises 15 min x 3/wk x11 wk**	**33**	**XXX.XX**
0111111110	**1234567890**	**G0283**	**GP**				**11**	**E Stim**	**33**	**XXX.XX**

An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.

24. Total Charges	**XXX.XX**

25. **SIGNATURE** — Requesting Provider	26. Date Signed
I.M. Provider	**MM/DD/CCYY**

ATTACHMENT 5
Sample Prior Authorization Request Form for Occupational Therapy Services

(A sample copy of the "Prior Authorization Request Form [PA/RF]" for occupational therapy services is located on the following page.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11018 (10/08)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code
HFS 152.06(3)(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

SECTION I — PROVIDER INFORMATION

1. Check only if applicable	2. Process Type	3. Telephone Number — Billing Provider
❑ HealthCheck "Other Services" ❑ Wisconsin Chronic Disease Program (WCDP)	**112**	**(XXX) XXX-XXXX**

4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code)	5a. Billing Provider Number	5b. Billing Provider Taxonomy Code
I.M. Billing Provider **609 Willow St** **Anytown WI 55555-1234**	**0222222220**	**123456789X**

SECTION II — MEMBER INFORMATION

6. Member Identification Number	7. Date of Birth — Member	8. Address — Member (Street, City, State, ZIP Code)
1234567890	**MM/DD/CCYY**	**322 Ridge St** **Anytown WI 55555**

9. Name — Member (Last, First, Middle Initial)	10. Gender — Member
Member, Im A.	❑ Male ☒ Female

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

11. Diagnosis — Primary Code and Description	12. Start Date — SOI	13. First Date of Treatment — SOI
434.01		

14. Diagnosis — Secondary Code and Description	15. Requested PA Start Date
437.0 – Cerebral atherosclerosis	

16. Rendering Provider Number	17. Rendering Provider Taxonomy Code	18. Service Code	19. Modifiers 1	2	3	4	20. POS	21. Description of Service	22. QR	23. Charge
0111111110	**123456789X**	**97110**	**GO**				**11**	**Strengthening exercises** **15 min x 3/wk x 11 wk**	**33**	**XXX.XX**

An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.

24. Total Charges	**XXX.XX**

25. **SIGNATURE** — Requesting Provider	26. Date Signed
I.M. Provider	**MM/DD/CCYY**

ATTACHMENT 6
Sample Prior Authorization Request Form for Speech and Language Pathology Therapy Services

(A sample copy of the "Prior Authorization Request Form [PA/RF]" for speech and language pathology services is located on the following page.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11018 (10/08)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code
HFS 152.06(3)(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

SECTION I — PROVIDER INFORMATION

1. Check only if applicable	2. Process Type	3. Telephone Number — Billing Provider
❑ HealthCheck "Other Services" ❑ Wisconsin Chronic Disease Program (WCDP)	**113**	**(XXX) XXX-XXXX**

4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code)	5a. Billing Provider Number	5b. Billing Provider Taxonomy Code
I.M. Billing Provider **609 Willow St** **Anytown WI 55555-1234**	**0222222220**	**123456789X**

SECTION II — MEMBER INFORMATION

6. Member Identification Number	7. Date of Birth — Member	8. Address — Member (Street, City, State, ZIP Code)
1234567890	**MM/DD/CCYY**	**322 Ridge St** **Anytown WI 55555**

9. Name — Member (Last, First, Middle Initial)	10. Gender — Member
Member, Im A.	❑ Male ☒ Female

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

11. Diagnosis — Primary Code and Description	12. Start Date — SOI	13. First Date of Treatment — SOI
434.01		

14. Diagnosis — Secondary Code and Description	15. Requested PA Start Date
437.0 – Cerebral atherosclerosis	**MM/DD/CCYY**

16. Rendering Provider Number	17. Rendering Provider Taxonomy Code	18. Service Code	19. Modifiers 1	2	3	4	20. POS	21. Description of Service	22. QR	23. Charge
0111111110	**123456789X**	**92506**					**11**	**Speech/Language Evaluation**	**1**	**XXX.XX**
0111111110	**123456789X**	**92507**					**11**	**Speech/Language Therapy**	**17**	**XXX.XX**
0111111110	**123456789X**	**92508**					**11**	**Group Speech/Language Therapy**	**17**	**XXX.XX**

An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.

24. Total Charges	**XXX.XX**

25. **SIGNATURE** — Requesting Provider	26. Date Signed
I.M. Provider	**MM/DD/CCYY**

ATTACHMENT 7
Prior Authorization/Therapy Attachment (PA/TA) Completion Instructions

(A copy of the "Prior Authorization/Therapy Attachment [PA/TA] Completion Instructions" is located on the following pages.)

FORWARDHEALTH
PRIOR AUTHORIZATION / THERAPY ATTACHMENT (PA/TA) COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

The use of this form is mandatory when requesting PA for certain services. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a reasonable judgment about the case.

Each provider must submit sufficient detailed information. Sufficient detailed information on a PA request means enough clinical information regarding the member to meet ForwardHealth's definition of "medically necessary." "Medically necessary" is defined in HFS 101.03(96m), Wis. Admin. Code. Each PA request is unique, representing a specific clinical situation. Therapists typically consider a number of issues that influence a decision to proceed with therapy treatment at a particular frequency to meet a particular goal. Those factors that influence treatment decisions should be documented on the PA request. ForwardHealth's therapy consultants will consider documentation of those same factors to determine whether or not the request meets ForwardHealth's definition of "medically necessary." ForwardHealth's consultants cannot "fill in the blanks" for a provider if the documentation is insufficient or unclear. The necessary level of detail may vary with each PA request and within the various sections of a PA request.

These directions are formatted to correspond to each required element on the Prior Authorization/Therapy Attachment (PA/TA), F-11008. The **bold** headings directly reflect the name of the element on the PA/TA. The proceeding text reflects instructions, hints, examples, clarification, etc., that will help the provider document medical necessity in sufficient detail.

Attach the completed PA/TA to the Prior Authorization Request Form (PA/RF), F-11018, and send it to ForwardHealth. Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

SECTION I — MEMBER / PROVIDER INFORMATION

Enter the following information into the appropriate box:

Element 1 — Name — Member
Enter the member's last name, followed by his or her first name and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or the spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters.

Element 3 — Age — Member
Enter the age of the member in numerical form (e.g., 16, 21, 60).

Element 4 — Name and Credentials — Therapist
Enter the treating therapist's name and credentials. If the treating therapist is a therapy assistant, enter the name of the supervising therapist and the name of the therapy assistant.

Element 5 — Therapist's National Provider Identifier
Enter the treating therapist's National Provider Identifier (NPI). If the treating therapist is the therapy assistant, enter the NPI of the supervising therapist. Rehabilitation agencies do not indicate an NPI.

Element 6 — Telephone No. — Therapist
Enter the treating therapist's telephone number, including area code and extension (if applicable). If the treating therapist is a therapy assistant, enter the telephone number of the supervising therapist.

Element 7 — Name — Referring / Prescribing Physician
Enter the referring or prescribing physician's name.

Element 8 — Requesting PA for Physical Therapy, Occupational Therapy, Speech and Language Pathology
Check the appropriate box on the PA/TA for the type of therapy service being requested.

Element 9 — Total Time Per Day Requested
Enter the anticipated number of minutes a typical treatment session will require. It is expected the requested minutes per session will be consistent with the member's history, age, attention span, cognitive ability, medical status, treatment goals, procedures, rehabilitation potential, and any other intervention the member receives. Intensity of intervention is determined by rate of change, rather than level of severity.

Element 10 — Total Sessions Per Week Requested
Enter the number of treatment days per week requested. It is expected the requested number of treatment days per week will be consistent with the member's history, medical status, treatment goals, rehabilitation potential, and any other intervention the member receives. Intensity of intervention is determined by rate of change, rather than level of severity.

Element 11 — Total Number of Weeks Requested
Enter the number of weeks requested. The requested duration should be consistent with the member's history, medical status, treatment goals, rehabilitation potential, and any other intervention the member receives. The requested duration should correspond to the number of weeks required to reach the goals identified in the plan of care. Intensity of intervention is determined by rate of change, rather than level of severity.

Element 12 — Requested Start Date
Enter the requested start date for this PA request in MM/DD/CCYY format.

Be sure:
- The member's name corresponds with the member ID listed.
- The member ID has all digits correctly listed.
- The member is currently enrolled for ForwardHealth.
- The provider's name and NPI match.

Note: All of the information in this section must be complete, accurate, and exactly the same as the information from ForwardHealth's EVS and on the PA/RF before the PA request is forwarded to a ForwardHealth's consultant. *Incomplete or inaccurate information will result in a returned PA request.*

SECTION II — PERTINENT DIAGNOSES / PROBLEMS TO BE TREATED

Element 13 — Provide a description of the member's current treatment diagnosis, any underlying conditions, and problem(s) to be treated, including dates of onset.

Indicate the pertinent medical diagnoses that relate to the reasons for providing therapy for the member at this time AND any underlying conditions that may affect the plan of care or outcome (e.g., dementia, cognitive impairment, medications, attention deficits). Include dates of onset for all diagnoses. If the date of onset is unknown, state "unknown."

If this documentation is on a previous PA request and is still valid, indicate "this documentation may be found on PA No. (provide the correct number for new PAs) XXXXXXXXXX." Providers should review this information for accuracy each time that they submit a PA request.

Note: Avoid copying the same information on subsequent PA requests without verifying that the information continues to be accurate. A PA request may be returned if it appears as if there has been no change documented under Section II, but other sections of the PA suggest there have been some changes to the member's medical/functional condition/need.

Example 1: A member without cognitive impairment may attain a goal to learn a task in one to three visits. However, achieving the same treatment goal for a cognitively impaired member may require additional visits. Knowledge of the member's cognitive abilities is critical to understanding the need for the requested additional visits.

Example 2: When the member has a medical diagnosis, such as Parkinson's disease or a pervasive developmental disorder, it is necessary to document the medical diagnosis *as well as* the problem(s) being treated. Listing the problem(s) to be treated without a medical diagnosis, or vice versa, is insufficient.

SECTION III — BRIEF PERTINENT MEDICAL / SOCIAL INFORMATION

Element 14 — Include referral information, living situation, previous level of function, any change in medical status since previous PA request(s), and any other pertinent information.

The ForwardHealth consultant needs to understand the complete "picture" of the member and take into consideration the member's background, personal needs, status, change in status, etc. Sufficient, but pertinent, documentation of a member's medical/social status may include:

- Conditions that may affect the member's outcome of treatment.
- Evidence that this member will benefit from therapy at this time.
- Reasons why a ForwardHealth-reimbursed service is being requested at this time (this is helpful when this is not a new diagnosis or is a continuing episode of care for this member).

The provider's documentation must include the factors considered when developing the member's plan of care. Such factors may be:

- Reasons for referral.
- Referral source (e.g., a second opinion, nursing having difficulty with carry-over program, school therapist referred because school does not have equipment to make orthotics).
- Reason(s) the member's medical needs are not met under current circumstances.
- Recent changes (e.g., change in medical status, change in living status) with reference dates.
- Member's goal (e.g., member's motivation to achieve a new goal may have changed).
- Member's living situation.
- Residence (e.g., nursing home vs. independent living).
- Caregiver (who is providing care [specific name not required], how frequently available, ability to follow through with instructions, etc.).
- If caregiver is required — the level of assistance required, the amount of assistance required, the type of assistance required.
- Degree of family support.
- Equipment and/or environmental adaptations used by the member.
- Brief history of the member's previous functional status.
- Prior level of function.
- Level of function after last treatment episode with reference dates.
- Cognition/behavior/compliance.
- Any other pertinent information that indicates a need for therapy services at this time.

SECTION IV — PERTINENT THERAPY INFORMATION

Element 15 — Document the chronological history of treatment provided for the diagnoses (identified under Section II), dates of those treatments, and the member's functional status following those treatments.

Summarize previous episodes of care, if applicable, in the chart provided in this section. If this is a new patient, include history taken from the member, member's caregivers, or patient file. Include knowledge of other therapy services provided to the member (e.g., if requesting a PA for speech and language pathology, include any occupational therapy or physical therapy the member may have received as well). Be concise, but informative.

Element 16 — List other service providers that are currently accessed by the member for those treatment diagnoses identified under Section II (i.e., home health, school, behavior management, home program, dietary services, therapies). Briefly document the coordination of the therapy treatment plan with these other service providers. Documentation may include telephone logs, summarization of conversations or written communication, copies of plans of care, staffing reports, or received written reports.

Document the coordination of the therapy treatment plan with other service providers that may be working to achieve the same, or similar, goals for the member. If there are no other providers currently treating the member, indicate "not applicable" in the space provided.

Element 17 — Check the appropriate box (on the PA/TA) and circle the appropriate form, if applicable:

- ❑ **The current Individualized Education Program (IEP) / Individualized Family Service Plan (IFSP) / Individual Program Plan (IPP) is attached to this PA request.**
- ❑ **The current IEP / IFSP / IPP is attached to PA number_____.**
- ❑ **There is no IEP / IFSP / IPP because _____.**
- ❑ **Cotreatment with another therapy provider is within the plan of care.**
- ❑ **Referenced report(s) is attached (list any report[s])_____.**

The IEP, IFSP, and IPP are reports used as follows:

- Individualized Education Plan — A written plan for a 3- to 21-year-old child who receives exceptional education services in school.
- Individualized Family Service Plan — A written plan for a 0- to 3-year-old child who receives therapy services through the Birth to 3 Program.
- Individualized Program Plan — A written active treatment plan for individuals who reside in an Intermediate Care Facility for the Mentally Retarded.

Submission of the IEP, IFSP, and IPP with the PA request is required if the member is receiving services that require one of the above written plans.

This section is included as a quick reference to remind providers to attach the necessary documentation materials to the PA request and to remind providers to document cotreatment, if applicable, in their plan of care.

Cotreatment is when two therapy types provide their respective services to one member during the same treatment session. For example, occupational therapists and physical therapists treat the member at the same time or occupational therapists and speech-language pathologists treat the member at the same time. It is expected that the medical need for cotreatment be documented in both providers' plans of care and that *both* PA requests are submitted *in the same envelope*.

Other "referenced reports" may be swallow studies, discharge summaries, surgical reports, dietary reports, or psychology reports. These reports should be submitted with the PA request when the information in those reports influenced the provider's treatment decision making and were referenced elsewhere in the PA request. Prior authorization requests submitted without the required or referenced documentation attached to the PA request will be returned to the provider.

SECTION V — EVALUATION (COMPREHENSIVE RESULTS OF FORMAL / INFORMAL TESTS AND MEASUREMENTS THAT PROVIDE A BASELINE FOR THE MEMBER'S FUNCTIONAL LIMITATIONS)

Element 18 — Attach a copy of the initial evaluation or the most recent evaluation or re-evaluation, *or* indicate with which PA number this information was previously submitted.

- ❑ **Comprehensive initial evaluation attached. Date of initial comprehensive evaluation _____.**
- ❑ **Comprehensive initial evaluation submitted with PA number _____.**
- ❑ **Current re-evaluation attached. Date of most current evaluation or re-evaluation(s) _____.**
- ❑ **Current re-evaluation submitted with PA number _____.**

A copy of the comprehensive evaluation for the current episode of care (for the current problem being treated) must be included with the PA request or submitted previously with another PA request, regardless of when treatment was initiated, and regardless of the reimbursement source at the time of the comprehensive evaluation. An evaluation defining the member's overall functional abilities and limitations with baseline measurements, from which a plan of care is established, is necessary for the ForwardHealth consultant to understand the member's needs and the request.

The initial evaluation must:

(1) Establish a baseline for identified limitations — The evaluation should provide baseline measurements that establish a performance (or ability) level, *using units of objective measurement that can be consistently applied when reporting subsequent status*. It is very important to use consistent units of measurement throughout documentation or be able to explain why the units of measurement changed.

Example 1: If the functional limitation is "unable to brush teeth," the limiting factor may be due to strength, range of motion, cognition, sensory processing, or equipment needs. The baseline should establish the status of identified limiting factors. Such factors may include:

- Range of motion measurements in degrees.
- Eye-hand coordination as measured by a testing tool or units of speed and accuracy.
- Oral sensitivity as measured by an assessment tool or type of reaction to specific kinds of textures or temperatures at specific oral cavity/teeth location.
- Grasp deficits including type of grasp and grip strength.

Later on, subsequent progress must be described using the same terms (e.g., grip strength increased by 2 pounds).

Example 2: If the functional limitation is "unable to sit long enough to engage in activities," indicate "the member can short sit for two minutes, unsupported, before losing his balance to the left." Later on, progress can be documented in terms of time.

(2) Relate the functional limitations to an identified deficit — The evaluation must be comprehensive enough that another, independent clinician would reasonably reach the same conclusion regarding the member's functional limitation.

Example 1: The member is referred to therapy because "she doesn't eat certain types of foods." The evaluation should clearly indicate the reason for not eating those certain foods. A deficit has not been identified if testing indicates the member only eats Food "B." Some deficit examples (for not eating a variety of foods) are: cleft palate, oral defensiveness, lip closure, tongue mobility, an aversion to food, aspiration, attention span, member is G-tube fed and is, therefore, not hungry. The identified deficit must be objectively measured and quantified (i.e., a baseline — see above).

Example 2: The member is referred to therapy because "he cannot go up and down stairs safely." The evaluation should clearly indicate the reasons for this functional limitation. A deficit has not been identified if the results of testing indicate the member can only step up three inches. Strength, range of motion, balance, sensory processing, motivation, etc., must be assessed and documented to identify the deficit causing the functional limitation (i.e., objectively tested, measured, and quantified on the evaluation).

A re-evaluation is the process of performing selected tests and measures (after the initial evaluation) in the targeted treatment area(s) to evaluate progress, functional ability, treatment effectiveness, and/or to modify or redirect intervention. The re-evaluation must be submitted with the PA request whenever it is necessary to update the member's progress/condition. Using the same tests and measurements as used in the initial evaluation is essential to reviewing status/progress. If new tests or measurements are used in the re-evaluation, explain why a different measurement tool was used.

SECTION VI — PROGRESS

Element 19 — Describe progress in specific, measurable, objective, and functional terms (using consistent units of measurement) that are related to the goals / limitations, *since treatment was initiated or last authorized*.

(If this information is concisely written in other documentation prepared for the provider's/therapist's records, attach and write "see attached" in the space provided.)

Document the goal or functional limitation in the left column on the PA/TA. Indicate the corresponding status for that goal or limitation *as of the previous PA request or since treatment was initiated (whichever is most recent)* in the middle column on the PA/TA. Indicate the corresponding status of that goal or limitation *as of the date of the current PA request* (do not use "a month ago" or "when last seen" or "when last evaluated") in the third column of the PA/TA. Progress relates to the established baseline, previous goals, and identified limitations. Use the same tests and measurements as those units of measurement used in the baseline description.

The following information is necessary to evaluate the medical necessity of the PA request:

- Progress documented in specific, measurable, and objective terms.
- Use of words that are specific, measurable, or objective. (Words such as better, improved, calmer, happier, pleasant, less/more, not as good, not as reliable, longer, more prolonged, and "goal not met" are not specific, measurable, or objective.) These do not convey to the ForwardHealth consultant if, or how much, progress has been achieved. The following examples are specific, measurable, and objective:
  Example 1: Strength increased from POOR to FAIR, as determined with a Manual Muscle Test.
  Example 2: Speech intelligibility improved from 30% to 70%, per standardized measurement.

- Consistent use of the same tests and measurements and units of measurement.
  Example: A progress statement that notes the member can now eat hamburgers does not correlate to his goal of articulation and the baseline established for articulation.
- Progress must demonstrate the member has learned new skills and, therefore, has advanced or improved in function ***as a result of*** treatment intervention. "If treatment of underlying factors, such as increase in endurance, strength or range of motion or decrease in pain does not improve the performance of functional activities, then improvement is not considered to be significant" (Acquaviva, p. 85).

  "Significant functional progress: Must result from treatment rather from maturation or other uncontrolled factors, must be real, not random, must be important, not trivial" (Bain and Dollaghan).

- Significant functional progress must have been demonstrated within the past six months for continued therapy PA approval. Prior authorization requests for treatment when the member has not advanced or improved function within six months cannot be approved, HFS 107.16(3)(e)1, HFS 107.17(3)(e)1, and HFS 107.18(3)(e)1, Wis. Admin. Code.
- Prior authorization requests for maintenance therapy must demonstrate the functional purpose (medical necessity) of treatment, as "progress" is not necessarily applicable to maintenance programs. The ForwardHealth consultant will look for evidence that there is a continued functional purpose for the member as a result of skilled therapeutic intervention, in accordance with the Wisconsin Administrative Code and applicable service-specific publications.

SECTION VII — PLAN OF CARE

Element 20 — Identify the specific, measurable, objective, and functional goals for the member (to be met by the end of this PA request) and both of the following:
(1) Indicate the therapist-required skills / treatment techniques that will be used to meet each goal.
(2) Designate (with an asterisk[*]) which goals are reinforced in a carry-over program.

If the plan of care is concisely written in other documentation prepared for the member's records, attach and write "see attached" in the space provided.

Examples for this section include:
1. GOAL: Client will be 80% intelligible in conversation as judged by an unfamiliar listener.
   Plan of care: Oral motor exercises, environmental cues, articulation skills.
2. GOAL: Client will increase vocabulary with five new words as reported by parent.
   Plan of care: Sing songs, read books, and use adjectives and adverbs in conversation.*
3. GOAL: Client will ascend stairs reciprocally without assistance.
   Plan of care: Gastrocnemius and gluteus medius strengthening.
4. GOAL: Client will transfer into and out of tub with verbal cues.
   Plan of care: Prepare bathroom and client for transfer; provide consistent verbal cues as rehearsed in PT.*
5. GOAL: Client will demonstrate ability to button ½-inch button on dress shirt independently using any pinch pattern.
   Plan of care: Graded finger grasp/pinch strengthening, eye-hand coordination, and bilateral hand use.
6. GOAL: Client will catch/throw a 10" ball.
   Plan of care: Practice play catch while sitting using a variety of objects, e.g., Nerf® ball, plastic ball, beach ball, volleyball, or balloon.*

It is very important to:
- Use consistent units of measurement.
- Document those elements of a treatment plan that only a skilled therapist could implement (e.g., 1, 3, and 5 above).
- Designate (with an asterisk [*]) those goals or interventions the provider has instructed other caregivers or the member to incorporate into the member's usual routine in his or her usual environment (such as 2, 4, and 6 above where kicking a ball, jumping, throwing a ball, building endurance, rote activities, who/what/where questions, using appropriate pronouns, choosing new foods, etc., are part of the overall plan of care).
- Write goals consistent with functional limitations and identified deficit as described in the evaluation and status statements (Section V) or progress section (Section VI).

Example: The evaluation identified the functional limitation and deficits corresponding to the above examples. Examples of limitations and deficits may include:
1. The client is not intelligible in conversation due to poor tongue control.
2. The 24-month-old client cannot express his needs because he has the vocabulary of a 16-month-old.
3. The client cannot get to his bedroom independently because of POOR muscle strength.
4. The client cannot safely get into the bathtub because he has poor short-term memory and is easily distractible.
5. The client cannot dress independently because of decreased fine-motor skills as tested on the Peabody and he lacks all functional pinch patterns.
6. The client cannot use hands/arms bilaterally because of poor left upper-extremity proximal stability.

SECTION VIII — REHABILITATION POTENTIAL

Element 21 — Complete the following sentences based upon the professional assessment.

These specific questions are asked to avoid one-word responses (e.g., "good"). Information beyond a one-word response provides the ForwardHealth consultant with additional detail that supports the justification that therapy services are necessary to meet the member's goals. ForwardHealth recognizes that the statements in this section are considered professional judgments and may not reflect the actual outcome of treatment.

(1) Upon discharge from this episode of care, the member will be able to

Describe what the member will be able to *functionally do* at the end of this episode of care (not necessarily the end of the PA request) based upon the professional assessment. Discharge planning begins at the initial evaluation. At the initial evaluation, the therapist should be able to determine the amount/type of change the member is capable of making based upon all the factors presented at the evaluation. Statements such as "will be age appropriate," "will resume prior level of function," "will have effects of multiple sclerosis minimized," or "will eat all foods" are vague and frequently are not achievable with the patient population therapists encounter. More member-specific or definitive statements of prognosis would be the following examples:

- "Return to home to live with spouse support."
- "Communicate basic needs and wants with her peers."
- "Go upstairs to his bedroom by himself."
- "Get dressed by herself."
- "Walk in the community with stand-by assistance for safety."
- "Walk to the dining room with or without assistive device and the assistance of a nurse's aide."
- "Swallow pureed foods."

(2) Upon discharge from this episode of care, the member may continue to (list supportive services)

Indicate what community or therapy services the member may continue to require at the end of this episode of care. Examples include:

- "Range of motion program by caregivers."
- "Infrequent (be specific) screening by therapist to assure maintenance of skills."
- "A communication book."
- "Behavior management services."
- "Dietary consultation."
- "Supervision of (a task) by a caregiver."

(3) The member / member's caregivers support the therapy plan of care by the following activities and frequency of carryover

Describe what activities the member and/or caregivers do or do not do with the member that will affect the outcome of treatment.

(4) It is estimated this episode of care will end (provide approximate end time)

Establish an anticipated time frame for the member to meet his or her realistic functional goals (e.g., two weeks, two months, two years).

Element 22 — SIGNATURE — Providing Therapist
The providing therapist's signature is required at the end of the PA/TA.

Element 23 — Date Signed
Enter the month, day, and year the PA/TA was signed (in MM/DD/CCYY format) by the providing therapist.

Element 24 — SIGNATURE — Member or Member Caregiver (optional)
The member's or member caregiver's signature is optional at this time, but is encouraged (as a means to review what has been requested on the member's behalf on the PA request).

Element 25 — Date Signed
Enter the month, day, and year the PA/TA was signed (in MM/DD/CCYY format) by the member or member's caregiver (if applicable).

If the required documentation is missing from the request form, the request will be returned to the provider for the missing information.

REMINDER: The PA/RF must be filled out completely (i.e., all sections completed). Attach the completed PA/TA and any other documentation to the PA/RF.

REFERENCES

Acquaviva, J.D., ed. (1992). Effective Documentation for Occupational Therapy. Rockville, Maryland, The American Occupational Therapy Association, Inc.

Bain and Dollaghan (1991). Language, Speech and Hearing Services in Schools, 13

Moyers, P.A. (1999). “The Guide to Occupational Therapy Practice.” American Journal of Occupational Therapy (Special Issue), 53 (3)

American Physical Therapy Association, 2001, Guide to Physical Therapist Practice, Physical Therapy, 81 (1)

American Physical Therapy Association, 1997, Guide to Physical Therapist Practice, Physical Therapy, 77 (11)

American Speech-Language and Hearing Association, 1997, Cardinal Documents

American Occupational Therapy Association Standards of Practice

American Physical Therapy Association Standards of Practice

American Speech-Language and Hearing Association Standards of Practice

Wisconsin Administrative Code

ATTACHMENT 8
Prior Authorization/Therapy Attachment (PA/TA) (for photocopying)

(A copy of the "Prior Authorization/Therapy Attachment [PA/TA]" is located on the following pages.)

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DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11008 (10/08)

STATE OF WISCONSIN
HFS 107.18(2), Wis. Admin. Code
HFS 152.06(3)(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH

PRIOR AUTHORIZATION / THERAPY ATTACHMENT (PA/TA)

Providers may submit prior authorization (PA) requests with attachments to ForwardHealth by fax at (608) 221-8616 or by mail to ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Therapy Attachment (PA/TA) Completion Instructions, F-11008A.

SECTION I — MEMBER / PROVIDER INFORMATION

1. Name — Member (Last, First, Middle Initial)	2. Member Identification Number	3. Age — Member
4. Name and Credentials — Therapist	5. Therapist's National Provider Identifier	6. Telephone No. — Therapist
7. Name — Referring / Prescribing Physician	8. Requesting PA for ❑ Physical Therapy ❑ Occupational Therapy ❑ Speech and Language Pathology	
9. Total Time Per Day Requested	10. Total Sessions Per Week Requested	
11. Total Number of Weeks Requested	12. Requested Start Date	

SECTION II — PERTINENT DIAGNOSES / PROBLEMS TO BE TREATED

13. Provide a description of the member's current treatment diagnosis, any underlying conditions, and problem(s) to be treated, including dates of onset.

SECTION III — BRIEF PERTINENT MEDICAL / SOCIAL INFORMATION

14. Include referral information, living situation, previous level of function, any change in medical status since previous PA request(s), and any other pertinent information.

SECTION IV — PERTINENT THERAPY INFORMATION

15. Document the chronological history of treatment provided for the diagnoses (identified under Section II), dates of those treatments, and the member's functional status following those treatments.

Provider Type (e.g., occupational therapy, physical therapy, speech and language pathology)	Dates of Treatment	Functional Status After Treatment

Continued

SECTION IV — PERTINENT THERAPY INFORMATION (Continued)

16. List other service providers that are currently accessed by the member for those treatment diagnoses identified under Section II (i.e., home health, school, behavior management, home program, dietary services, therapies). Briefly document the coordination of the therapy treatment plan with these other service providers. Documentation may include telephone logs, summarization of conversations or written communication, copies of plans of care, staffing reports, or received written reports.

17. Check the appropriate box and circle the appropriate form, if applicable.

- ❑ The current Individualized Education Program (IEP) / Individualized Family Service Plan (IFSP) / Individual Program Plan (IPP) is attached to this PA request.
- ❑ The current IEP / IFSP / IPP is attached to PA number _____.
- ❑ There is no IEP / IFSP / IPP because_____
  _____.
- ❑ Cotreatment with another therapy provider is within the plan of care.
- ❑ Referenced report(s) is attached (list any report[s]) _____.

SECTION V — EVALUATION (COMPREHENSIVE RESULTS OF FORMAL / INFORMAL TESTS AND MEASUREMENTS THAT PROVIDE A BASELINE FOR THE MEMBER'S FUNCTIONAL LIMITATIONS)

18. Attach a copy of the initial evaluation or the most recent evaluation or re-evaluation, **or** indicate with which PA number this information was previously submitted.

- ❑ Comprehensive initial evaluation attached. Date of initial comprehensive evaluation _____.
- ❑ Comprehensive initial evaluation submitted with PA number _____.
- ❑ Current re-evaluation attached. Date of most current evaluation or re-evaluation(s) _____.
- ❑ Current re-evaluation submitted with PA number _____.

SECTION VI — PROGRESS

19. Describe progress in specific, measurable, objective, and functional terms (using consistent units of measurement) that are related to the goals / limitations, *since treatment was initiated or last authorized*.

Goal / Limitation	Previous Status / Date	Status as of Date of PA Request / Date

(If this information is concisely written in other documentation prepared for the provider's/therapist's records, attach and write "see attached" in the space above.)

Continued

SECTION VII — PLAN OF CARE

20. Identify the specific, measurable, objective, and functional goals for the member (to be met by the end of this PA request) and both of the following:
    (1) Indicate the therapist-required skills / treatment techniques that will be used to meet each goal.
    (2) Designate (with an asterisk [*]) which goals are reinforced in a carry-over program.

(If the plan of care is concisely written in other documentation prepared for the member's records, attach and write "see attached" in the space above.)

SECTION VIII — REHABILITATION POTENTIAL

21. Complete the following sentences based upon the professional assessment.
    (1) Upon discharge from this episode of care, the member will be able to

    (2) Upon discharge from this episode of care, the member may continue to (list supportive services)

    (3) The member / member's caregivers support the therapy plan of care by the following activities and frequency of carryover

    (4) It is estimated this episode of care will end (provide approximate end time)

22. **SIGNATURE —** Providing Therapist	23. Date Signed
24. **SIGNATURE —** Member or Member Caregiver (optional)	25. Date Signed

ATTACHMENT 9
Prior Authorization/Spell of Illness Attachment (PA/SOIA) Completion Instructions

(A copy of the "Prior Authorization/Spell of Illness Attachment [PA/SOIA] Completion Instructions" is located on the following pages.)

FORWARDHEALTH
PRIOR AUTHORIZATION / SPELL OF ILLNESS ATTACHMENT (PA/SOIA) COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of the Prior Authorization/Spell of Illness Attachment (PA/SOIA), F-11039, is mandatory when requesting spell of illness (SOI). Providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

Attach the completed PA/SOIA to the Prior Authorization Request Form (PA/RF), F-11018, and send it to ForwardHealth. Providers may submit PA requests by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

An SOI ends when the maximum allowable treatment days have been used or when the physical therapy (PT), occupational therapy (OT), or speech and language pathology (SLP) services are no longer required, whichever comes first. If, near the end of the maximum allowable treatment days, the skills of a PT, OT, or SLP provider are still needed, the provider should submit the PA/RF and the Prior Authorization/Therapy Attachment (PA/TA), F-11008, to continue services.

SECTION I — MEMBER INFORMATION

Element 1 — Name — Member
Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Age — Member
Enter the age of the member in numerical form (e.g., 16, 21, 60).

Element 3 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

SECTION II — PROVIDER INFORMATION

Element 4 — Name and Credentials — Therapist
Enter the name and credentials of the primary therapist participating in therapy services for the member. If the rendering provider is a therapy assistant, enter the name of the supervising therapist.

Element 5 — Therapist's National Provider Identifier
Enter the rendering provider's National Provider Identifier (NPI). If the rendering provider is a therapy assistant, enter the NPI of the supervising therapist. Rehabilitation agencies do not indicate a rendering provider.

Element 6 — Telephone Number — Therapist
Enter the rendering provider's telephone number, including the area code, of the office, facility, or place of business. If the rendering provider is a therapy assistant, enter the telephone number of the supervising therapist.

Element 7 — Name — Prescribing Physician
Enter the name of the prescribing physician.

SECTION III — DOCUMENTATION

Element 8
Enter an "X" in the appropriate box to indicate a PT, OT, or SLP SOI request.

Element 9 — Requested Start Date
Enter the requested start date for service(s) in MM/DD/CCYY format.

Element 10 — Primary *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) Diagnosis Code or ICD-9-CM Surgical Procedure Code
Enter the appropriate primary ICD-9-CM diagnosis code or surgical procedure code.

Element 11
Enter an "X" in the appropriate box to indicate "yes" or "no" in response to each statement. Only one of "A" through "F" must be marked "yes" in addition to "G" for SOI approval. Otherwise, the PT, OT, or SLP provider should submit the PA/RF and the PA/TA.

Element 12 — Signature — Therapist Providing Evaluation / Treatment
The signature of the therapist providing evaluation/treatment must appear in the space provided.

Element 13— Date Signed
Enter the month, day, and year the PA/SOIA was signed in MM/DD/CCYY format.

ATTACHMENT 10
Prior Authorization/Spell of Illness Attachment (PA/SOIA)
(for photocopying)

(A copy of the "Prior Authorization/Spell of Illness Attachment [PA/SOIA]" is located on the following pages.)

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DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11039 (10/08)

STATE OF WISCONSIN
HFS 107.18(2), 107.19(2), 107.20(2), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION / SPELL OF ILLNESS ATTACHMENT (PA/SOIA)

Providers may submit spell of illness (SOI) requests by fax to ForwardHealth at (608) 221-8616, or providers may send the completed form to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Spell of Illness Attachment (PA/SOIA) Completion Instructions, F-11039A.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)	2. Age — Member

3. Member Identification Number

SECTION II — PROVIDER INFORMATION

4. Name and Credentials — Therapist	5. Therapist's National Provider Identifier

6. Telephone Number — Therapist	7. Name — Prescribing Physician

SECTION III — DOCUMENTATION

8. Requesting SOI for ❑ Physical Therapy (PT) ❑ Occupational Therapy (OT) ❑ Speech and Language Pathology (SLP)

9. Requested Start Date	10. Primary *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) Diagnosis Code or ICD-9-CM Surgical Procedure Code

11. Indicate "yes" or "no" in response to ***each*** of the following statements (Only one of "A" through "F" in addition to "G" must be marked "yes" for SOI approval. Otherwise, the PT, OT, or SLP provider should submit the Prior Authorization Request Form [PA/RF] and the Prior Authorization/Therapy Attachment [PA/TA]).

A. The member experienced the onset of a new neuromuscular disease, injury, or condition six weeks ago or less.	❑ Yes	❑ No
B. The member experienced the onset of a new musculoskeletal disease, injury, or condition six weeks ago or less.	❑ Yes	❑ No
C. The member experienced the onset of a new problem or complication associated with physiologic disease, injury, or condition six weeks ago or less.	❑ Yes	❑ No
D. The member experienced the onset of a new psychological disease, injury, or condition six weeks ago or less.	❑ Yes	❑ No
E. The member experienced an exacerbation of a pre-existing condition six weeks ago or less.	❑ Yes	❑ No
F. The member experienced a regression of his or her condition due to lack of therapy six weeks ago or less.	❑ Yes	❑ No
AND		
G. There is a reasonable expectation that the member will return to his or her previous level of function by the end of this SOI or sooner.	❑ Yes	❑ No

I hereby certify that the documentation of the date of onset, exacerbation, or regression of the member's disease, injury, or condition is as stated above. The specific start date of the SOI is maintained in the member's medical record at my facility and I acknowledge that the SOI ends when the services of a therapist are no longer required or after the maximum allowable treatment days have been used, whichever comes first.

12. **SIGNATURE** — Therapist Providing Evaluation / Treatment	13. Date Signed

Continued

Examples of statements A-F from Element 11:

A. The member experienced the onset of a new neuromuscular disease, injury, or condition six weeks ago or less. Examples of this situation include, but are not limited to:

- Diabetic neuropathy.
- Multiple sclerosis.
- Parkinson's disease.
- Stroke-hemiparesis.

B. The member experienced the onset of a new musculoskeletal disease, injury, or condition six weeks ago or less. Examples of this situation include, but are not limited to:

- Amputation.
- Complications associated with surgical procedures.
- Fracture.
- Strains and sprains.

C. The member experienced the onset of a new problem or complication associated with physiologic disease, injury, or condition six weeks ago or less. Examples of this situation include, but are not limited to:

- Cardio-pulmonary conditions.
- Severe pain.
    - Vascular condition.

D. The member experienced the onset of a new psychological disease, injury, or condition six weeks ago or less. Examples of this situation include, but are not limited to:

- Affective disorders.
- Organic conditions.
- Thought disorders.

E. The member experienced an exacerbation of a pre-existing condition six weeks ago or less. Examples of this situation include, but are not limited to:

- Multiple sclerosis.
- Parkinson's disease.
- Rheumatoid arthritis.
- Schizophrenia.

F. The member experienced a regression of his or her condition due to lack of therapy six weeks ago or less. Examples of this situation include, but are not limited to:

- Decrease of functional ability.
- Decrease of mobility.
- Decrease of motion.
- Decrease of strength.

ATTACHMENT 11
Prior Authorization/Birth to 3 Therapy Attachment (PA/B3)
(for photocopying)

(A copy of the "Prior Authorization/Birth to 3 Therapy Attachment [PA/B3]" is located on the following page.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11011 (10/08)

STATE OF WISCONSIN
HFS 107.18(2), 107.19(2), 107.20(2), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION / BIRTH TO 3 ATTACHMENT (PA/B3)

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is mandatory when requesting PA for certain services. Refer to the applicable service-specific publications for service restrictions and documentation requirements.

REMINDER TO PROVIDERS
Providers are reminded that all services must meet the rules and regulations of ForwardHealth as found in HFS 101-108, Wis. Admin. Code. Providers are further reminded that prior authorization (PA) does not guarantee payment for the service.

SUBMITTING PRIOR AUTHORIZATION REQUESTS
Attach this form to the Prior Authorization Request Form (PA/RF), F-11018. Providers may submit PA requests by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

Providers should make duplicate copies of all paper documents mailed to ForwardHealth.

Name — Member (Last, First, Middle Initial)	Member Identification Number
Name — Therapist (Last, First, Middle Initial)	Therapist's or Rehabilitation Agency's National Provider Identifier

By my signature below, I hereby attest that:

- I am providing an evaluation completed for the purpose of determining the member's eligibility for the Birth to 3 (B-3) Program or for the purpose of initiating and/or providing therapy services as part of the Individualized Family Service Plan (IFSP) developed for the member.

OR

- I am providing ongoing therapy services, and I certify that all of the following are true:
  - The IFSP for the child named above was or will be developed and implemented in accordance with the requirements set forth in HFS 90, Wis. Admin. Code.
  - The therapy services I am providing to the member named above are as stated in the child's current and valid IFSP.
  - The frequency and duration of services I am providing to the child named above reflects the frequency and duration of services listed in the member's IFSP.
  - The member of the services is enrolled in a B-3 Program for all dates of service and is younger than three years of age.
  - I am a therapist employed by a B-3 Program or am under agreement with a B-3 agency to provide B-3 services.
  - The therapy services provided meet all the applicable rules and regulations as stated in HFS 101-108, Wis. Admin. Code, and ForwardHealth publications.
  - I understand that I am required to maintain a record of services provided to the child named above, per HFS 106, Wis. Admin. Code.

SIGNATURE — Therapist	Date Signed (MM/DD/CCYY)

ATTACHMENT 12
Prior Authorization Amendment Request Completion Instructions

(A copy of the "Prior Authorization Amendment Request Completion Instructions" is located on the following pages.)

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FORWARDHEALTH
PRIOR AUTHORIZATION AMENDMENT REQUEST COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

Providers are required to use the Prior Authorization Amendment Request, F-11042, to request an amendment to a PA. The use of this form is mandatory when requesting an amendment to a PA. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth medical consultants to make a reasonable judgment about the case.

Attach the completed Prior Authorization Amendment Request to the PA Decision Notice of the PA to be amended along with physician's orders, if applicable, (within 90 days of the dated signature) and send it to ForwardHealth. Providers may submit the Prior Authorization Amendment Request to ForwardHealth by fax at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — MEMBER INFORMATION

Element 1 — Original PA Number
Enter the unique PA number from the original PA to be amended.

Element 2 — Process Type
Enter the process type as indicated on the PA to be amended.

Element 3 — Member Identification Number
Enter the member ID as indicated on the PA to be amended.

Element 4 — Name — Member
Enter the name of the member as indicated on the PA to be amended.

SECTION II — PROVIDER INFORMATION

Element 5 — Billing Provider Number
Enter the billing provider number as indicated on the PA to be amended.

Element 6 — Name — Billing Provider
Enter the name of the billing provider as indicated on the PA to be amended.

SECTION III — AMENDMENT INFORMATION

Element 7 — **Address** — **Billing Provider**
Enter the address of the billing provider (include street, city, state, and ZIP+4 code) as indicated on the PA to be amended.

Element 8 — Requested Start Date
Enter the requested start date for the amendment in MM/DD/CCYY format if a specific start date is required.

Element 9 — Requested End Date (If Different from Expiration Date of Current PA)
Enter the requested end date for the amendment in MM/DD/CCYY format if the end date is different that the current expiration date.

Element 10 — Reasons for Amendment Request
Enter an "X" in the box next to each reason for the amendment request. Check all that apply.

Element 11 — Description and Justification for Requested Change
Enter the specifics and supporting rationale of the amendment request related to each reason indicated in Element 10.

Element 12 — Are Attachments Included?
Enter an "X" in the appropriate box to indicate if attachments are or are not included with the amendment request. If Yes, specify all attachments that are included.

Element 13 — Signature — Requesting Provider
Enter the signature of the provider that requested the original PA.

Element 14 — Date Signed — Requesting Provider
Enter the date the amendment request was signed by the requesting provider in MM/DD/CCYY format.

ATTACHMENT 13
Prior Authorization Amendment Request (for photocopying)

(A copy of the "Prior Authorization Amendment Request" is located on the following page.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11042 (10/08)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code
HFS 152.06(3(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION AMENDMENT REQUEST

Providers may submit prior authorization (PA) requests with attachments to ForwardHealth by fax at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Refer to the Prior Authorization Amendment Request Completion Instructions, F-11042A, for detailed information on completing this form.

SECTION I — MEMBER INFORMATION

1. Original PA Number	2. Process Type	3. Member Identification Number

4. Name — Member (Last, First, Middle Initial)

SECTION II — PROVIDER INFORMATION

5. Billing Provider Number	7. Address — Billing Provider (Street, City, State, ZIP+4 Code)
6. Name — Billing Provider	

SECTION III — AMENDMENT INFORMATION

8. Requested Start Date	9. Requested End Date (If Different from Expiration Date of Current PA)

10. Reasons for Amendment Request (Check All That Apply)

- ❑ Change Billing Provider Number
- ❑ Add Procedure Code / Modifier
- ❑ Change Procedure Code / Modifier
- ❑ Change Diagnosis Code
- ❑ Change Grant or Expiration Date
- ❑ Discontinue PA
- ❑ Change Quantity
- ❑ Other (Specify)_____

11. Description and Justification for Requested Change

12. Are Attachments Included? ❑ Yes ❑ No
If Yes, specify attachments below.

13. **SIGNATURE** — Requesting Provider	14. Date Signed — Requesting Provider